



## *Vermont . . .*

### **Department of Banking, Insurance, Securities and Health Care Administration**

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January 26, 2007

Representative Steve Maier, Chair  
House Health Care Committee

Representative Warren Kitzmiller, Chair  
House Commerce Committee

Senator Douglas Racine, Chair  
Senate Health and Welfare Committee

Senator Ann Cummings, Chair  
Senate Finance Committee

State House  
Montpelier, Vermont 05602

Re: Individual Health Insurance Market Study

Dear Legislators:

I am writing to you with the Individual Health Insurance Market Study required pursuant to Sec. 31 of Act 191, the Catamount Health reform legislation.

Sec. 31 directed the Department of Banking, Insurance, Securities and Health Care Administration, in consultation with insurers participating in the individual (or "nongroup") market, to recommend to the General Assembly "the best method to consolidate the nongroup market into a single risk pool of insured Vermonters with access to health plans equivalent to or better than that offered by Catamount Health."

At the beginning of the Department's work on this study, we convened meetings with the health insurers in the individual market (as directed by Act 191) to ascertain their perspective of the task, and to solicit their suggestions on how to approach the task. The health insurers who offer individual health insurance policies in Vermont are Blue Cross Blue Shield of Vermont, and MVP Health Plan, Inc. Both the health insurers and the Department agreed that the individual health insurance market is vulnerable at this time. Currently the individual market is characterized by declining enrollment, high premiums, and benefit plans with very significant cost sharing obligations imposed on insureds. The Department and the health insurers recognized, therefore, that in order to fulfill the Legislature's specific intent to study how best to "consolidate the nongroup market into a single risk pool", and to improve benefits covered under individual health insurance policies, the Department would need to examine the individual market in general. A more general study would focus on identifying the problems underlying the currently vulnerable status of the market, and analyze potential options for the Legislature to consider to address those problems.

The Department was also mindful that it has its hand full in implementing the various

provisions of Act 191 assigned to it, and that the Department had no specifically designated resources with which to carry out the Individual Health Insurance Market Study.

Accordingly, the Department, with the assistance of Susan Besio, Director of Health Care Reform Implementation, reached out to the nonprofit health care policy world, and secured a commitment from the Robert Wood Johnson program "State Coverage Initiatives" to fund professional and technical assistance. The Department was very fortunate to secure the services of Jack Meyer and Elliot Wicks of Health Management Associates, both of whom have a great deal of expertise in health care policy, and a long-standing, demonstrated commitment to national health care reform efforts.

Attached to this letter is Mr. Wicks' analysis "The Individual Market in Vermont: Problems and Possible Solutions". The first part of Mr. Wicks' analysis examines the current individual health insurance market in Vermont. Because of the inter-relationships between the small group/association market and the individual market, this first part also examines certain issues in the small group/association market as well, especially the extent to which exempt associations have distorted the original intent of community rating in Vermont. Mr. Wicks' conclusions as to the individual market are summarized as follows:

*"To sum up, the individual market seems to be performing badly: the number of people buying such coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing." (Page 15)*

The analysis conducted by Mr. Wicks identified a range of possible solutions for the individual market. Mr. Wicks was not asked to make specific recommendations for the individual market; he understood that his role in providing expert analysis was to identify possible solutions to the problems facing the individual market, and to analyze those possible solutions so that the Administration and the Legislature could then consider what policy decisions were appropriate under the circumstances.

From the range of options identified by Mr. Wicks, the Department suggests the following as potentially fruitful topics for further examination by the General Assembly. The Department is looking forward to working with the Legislature in further exploring these options, either separately or in combination, and in considering any other options for addressing the problems facing the individual health insurance market in Vermont:

1. **Government reinsurance.** Act 191 created a Nongroup Security Trust, to be administered by the Department, for the purpose of reducing premiums in the individual market. The Department has implemented the provisions of the Trust by applying for and receiving a \$1 million grant from the federal government to start up and administer a reinsurance mechanism for the nongroup market. The actual commencement of the Trust is dependent upon an appropriation of funds in Fiscal Year 2008 to subsidize the reinsurance mechanism. This reinsurance mechanism, if funded at a sufficient level, seems to be a viable existing option to assist Vermonters insured in the individual market.
2. **Examination in future years of direct subsidies for low and moderate income insureds.** This is another option that deserves further examination in future years as a means of encouraging Vermonters to remain insured in the individual market. The Department is mindful that when the Catamount Health premium assistance program begins in October 2007, there is the potential for migration to Catamount

Health policies from individuals who either are currently insured in the individual market, or who would purchase individual insurance in the absence of the Catamount Health premium assistance program. If this occurs, it will result in a smaller individual pool that is likely to be even less stable than it is now. Premium subsidies for low income Vermonters would help both these individuals and the market as a whole; however, given the need to balance the many competing and worthwhile needs of Vermonters, this is an option that should be pursued in the future once more data is available on migration and the number of individuals who might benefit from premium subsidies.

3. **Combining the Safety Net Pool with the rest of the individual market.** The express language of Sec. 31 of Act 191 asked that the Department consider this type of option in the study. The Safety Net Pool was enacted in 1992 to address problems faced by Vermonters whose health insurance company left the state in response to the community rating legislation enacted that year. Mr. Wicks and both health insurers concur that the rationale for the Safety Net Pool is no longer as strong as it was in the early 1990's, and that the individual market as a whole would benefit as a result of the combination. An appropriate transition period would need to be implemented in order to mitigate any sudden impact on insureds currently covered in the Safety Net Pool.
4. **Uniform rating rules.** MVP Inc. offers individual health insurance under statutory rating rules which permit limited age rating, thereby allowing the insurer to charge premiums which are 20% lower than the community rate for younger, usually healthier individuals, and which are 20% higher for older individuals. Blue Cross Blue Shield, however, is required to offer policies at a "pure" community rate. As a result, adverse selection can occur with negative consequences for the market as a whole. As with the option of combining the Safety Net Pool with the rest of the individual market, permitting all insurers to use uniform age rating rules would need to be implemented with an appropriate transition period in order to mitigate any sudden impact on some of the Vermonters currently insured by Blue Cross Blue Shield.
5. **Modification of the 75% rule.** The 75% rule is a statutory provision in Vermont's community rating laws which requires or permits certain insurers to drop coverage of a small business unless at least 75% of the employees of the small business are covered under the insurer's plan. This rule can have potentially harsh consequences for individuals and businesses. This issue was not expressly analyzed by Mr. Wick, but has been recently a source of many consumer and business complaints at the Department. The Department is concerned that in the absence of some modification to the 75% rule, some small businesses will drop their coverage, and those employees will have difficulty seeking coverage in the individual market.

The analysis conducted by Mr. Wicks also identified a number of other possible options which the Department does not believe warrant further examination at this time. These other options include:

- Longer waiting periods for pre-existing conditions. The Department feels this option is not consistent with the intent expressed by the Legislature and the Administration in the enactment of the Catamount Health reform legislation.

- Limiting enrollment to a shorter period during the year. Again, the Department feels this option is not consistent with the intent expressed by the Legislature and the Administration in enacting and signing the Catamount Health reform legislation.
- Allowing insureds in the individual market to enroll in Catamount Health. The Department believes that Catamount Health should be allowed to start up as currently enacted before any significant changes are made to the program's eligibility rules.
- High risk pool. The Department questions how effective a high risk pool would be in Vermont, and considers the enactment of the Nongroup Security Trust in Act 191 to be a better alternative.
- Combining the individual and small group markets. This is an option enacted in Massachusetts in their recent health care reform legislation, but because of the differences between the Massachusetts and Vermont legislation, the Department does not believe it should be considered a viable option in Vermont.
- Groups of one. This option would prohibit sole proprietors from being eligible to purchase small group or association market insurance. Until Vermont can improve the stability and affordability of Vermont's individual market, implementation of this option would have unreasonably harsh consequences for individuals.
- Individual mandate, or a universal coverage system. The Administration does not favor further examination of either of these options at this time. Catamount Health needs to be given time and the full support of the executive and legislative branches before significant changes to Vermont's health care reform plan are considered. The time and effort expended on examination of other alternative plans would detract from a successful Catamount Health implementation effort.

The individual health insurance market in Vermont is at a critical junction. The Department asks that the Legislature seriously consider the issues raised herein as together we seek to find solutions to the individual Vermonters who rely on the individual market for health insurance coverage. The Department looks forward to working with you in the months ahead on this important issue.

Sincerely,

Christine M. Oliver, Deputy Commissioner  
Division of Health Care Administration

cc: Paulette J. Thabault, Commissioner  
Susan Besio, Director of Health Care Reform Implementation  
Donald Milne, Clerk of the House of Representatives  
David A. Gibson, Secretary of the Senate  
Loring Starr, Legislative Council

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# **The Individual Market in Vermont: Problems and Possible Solutions**

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*prepared for*

Vermont Department of Banking, Insurance,  
Securities and Health Care Administration

*prepared by*

Elliot K. Wicks, Ph.D.

Health Management Associates  
2100 M Street, N.W., Suite 605  
Washington, DC 20037  
202 785-3669

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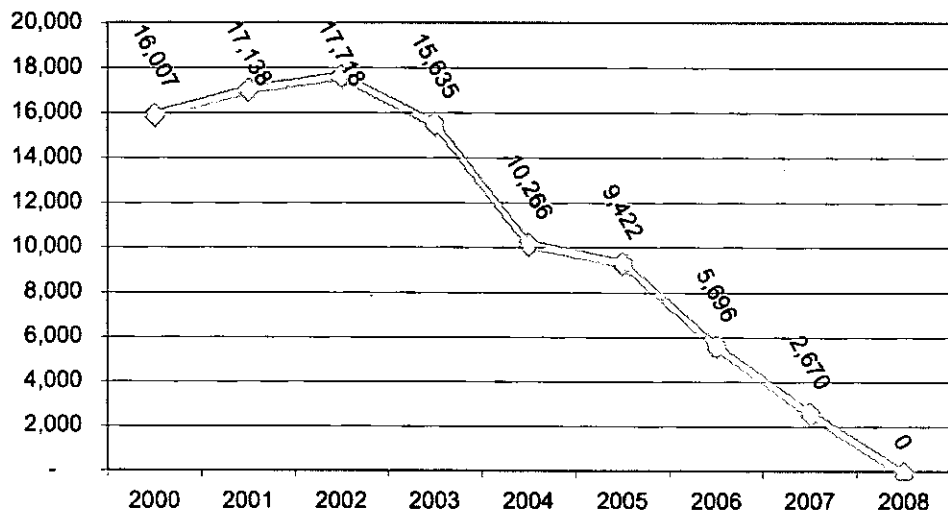
# The Individual Market in Vermont: Problems and Possible Solutions

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by Elliot K. Wicks, Ph.D.

The purpose of this paper is to identify ways to improve the workings of Vermont's individual health insurance market, which is perceived by many in the state to be performing poorly and perhaps to be in danger of failing. One major symptom of the problems are that enrollment is declining. Figure 1 shows that in 2003 enrollment began to decline and fell rapidly thereafter through 2005, the last year for which data is available. From 2002 through 2005, the number of covered lives fell by almost 8,300 or about 47 percent. If that trend were to continue (shown in the shaded portion of graph), by 2008, no one would be enrolled in the individual market.

**Figure 1**  
**Individual/Non-Group Covered Lives, 2000-2005 Actual, 2006-2008 Projected**



Source: 2005 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration.

## The Private Insurance Markets in Vermont

To provide context for assessing the individual market, it is useful to show how the people of Vermont are insured. Figure 2 below gives a snapshot of coverage sources for Vermont and compares that to the United States as a whole for 2005.

**Figure 2**  
**Source of Coverage, 2005, Vermont and United States**

	Vermont		United States	
	Lives	Percent	Lives	Percent
Employer	372,817	59.8	156,326,430	53
Individual	9,422	1.5	14,162,970	5
Medicaid	102,988	16.5	37,868,010	13
Medicare	92,573	14.9	34,654,120	12
Other Public	—	—	3,358,460	1
Uninsured	61,057	9.8	46,577,440	16
Total	623,050	100	292,947,440	100

Source: Vermont: 11997-2005 Annual Statement Supplement Reports, Vermont Dept. of Banking, Insurance, Securities and Health Care Administration. U.S.: Kaiser Family Foundation website, State Health Facts, [www.statehealthfacts.org](http://www.statehealthfacts.org).

About 61 percent of Vermont residents have private insurance. But only about 1.5 percent of Vermont residents get coverage through the individual market. In most states, the individual market plays a relatively small role, as Figure 2 shows, but the role is much smaller in Vermont.

### Employer-sponsored Coverage

In Vermont, as elsewhere, the private health insurance market is composed of a number of submarkets. As the data in Figure 2 show, most privately insured people (about 373,000 or 60 percent of the total population) have employer-sponsored coverage. Employers provide coverage in several ways. Self-insured employers are large firms that do not buy insurance but rather chose to absorb all of the risk themselves. This approach is practical because their work force is large enough that their medical claims costs are relatively predictable for the group as a whole. The risk is spread across the employer's work force: the high costs incurred by some workers in a year are offset by low medical costs or no costs for other workers in that year. Under the federal ERISA legislation, the state cannot regulate coverage plans of self-insured employers. They cannot be classified as insurers, and thus are not subject to state insurance laws. (ERISA prevents the state from directly regulating the benefit plans of *any* employer, self-insured or not. But because states can regulate *insurers*, they can indirectly regulate the kind of insurance that non-self-insured employers buy.) In 2005, about 111,000 Vermonters were in self-insured plans.

Another set of mostly middle-sized employers buy coverage from insurers. They are fully insured but are often "experience rated;" that is, the insurer takes on the risk in

any one year, but the next year's premium is adjusted depending on each employer's claims experience of the year just passed.

This leaves the small-employer market, which in Vermont is defined as employers having from 1 to 50 employees. (A self-employed person is a "group of one.") The small employer market is composed of two sub-markets—the community-rated market and the association market—and each is subject to its own set of insurance regulations. Under both federal and state law, insurers have to offer coverage on a guaranteed-issue basis to *all* small employers;<sup>1</sup> that is, no firm can be denied coverage because of the group's risk. The two sub-markets differ, however, in the way Vermont's community rating rules apply. In the community-rated portion of the small-employer market (hereafter referred to as the small-group market), every firm pays the same rate for comparable insurance; that is, the insurers cannot use an individual group's risk factors or prior claims experience in deciding how much to charge that group. But generally in the association market, community rating applies only *within* the association;<sup>2</sup> all groups in an association pay the same rate for the same coverage, but different associations can be charged different rates. So an association composed of employers with generally low-risk employees—perhaps an association of employers whose employees are aerobics instructors—pays a lower premium than an association in which the covered employees are less healthy, older, or otherwise at higher risk of incurring high medical costs. Small employers have the choice of whether to join an association, assuming they qualify for membership, or to buy in the community-rated small-group market. If they qualify for membership in several associations, they may have several coverage choices. Some associations have such open-ended standards for eligibility that almost any business can qualify to join. Naturally, the choice between the community-rated small-group market and the association market or among associations will generally depend upon which form of coverage is a "better deal." When health care costs and premiums rise rapidly, the incentives for shopping around and switching coverage sources to get a better deal are especially strong.

According to state data, in 2005, about 262,000 people were covered by *insured* employer plans (the number excludes self-insured employer plans.) See Figure 3 below.

### **The Individual or "Non-Group" Market**

Finally, there is the individual market (sometimes called the "non-group market"). It is referred to as the individual market because people are purchasing coverage on their own, often for themselves and their family, rather than through a group.

The individual market in Vermont differs from that of nearly all other states because insurers are required to community rate—or, more accurately, Blue Cross and Blue

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<sup>1</sup> Under federal law, a small group does not include "groups of one." The small-group market is defined as employers with 2 to 50 employees.

<sup>2</sup> Technically, only associations that have been deemed "exempt" associations are allowed to be experience rated rather than community rated. But most people insured through associations are in exempt associations.

Shield is required to use “pure” community rating, while for-profit insurers are allowed to adjust rates for age by plus or minus 20 percent. Most states allow much larger rate variation and the use of more rating factors. Vermont’s nearly unique form of rate regulation has important implications, which will be explored in detail later.

For the most part, the individual market serves primarily people who do not have access to employer-sponsored coverage. The reason is that purchasing coverage in the individual market is a second-best option for most people, for a variety of reasons.

**Figure 3**  
**Health Insurance Coverage Profile of Vermont Residents, 2001-2005**

COVERAGE SOURCE	2001		2002		2003		2004		2005	
<b>Private</b>	362,135	59.1%	359,751	58.3%	360,414	58.2%	358,425	57.7%	382,239	61.3%
<b>Employer-Sponsored</b>	344,997	56.3%	342,033	55.5%	344,779	55.7%	348,159	56.0%	372,817	59.8%
Small Employer	35,907	5.9%	33,048	5.4%	29,046	4.7%	24,325	3.9%	22,014	3.5%
Association	77,118	12.6%	82,443	13.4%	86,560	14.0%	96,282	15.5%	114,384	18.4%
Large Employer	84,414	13.8%	76,181	12.4%	78,753	12.7%	92,541	14.9%	84,707	13.6%
Blue Cross Blue Shield Blue Card	42,000	6.9%	42,000	6.8%	41,000	6.6%	41,000	6.6%	41,000	6.6%
Self-insured Employer	105,558	17.2%	108,361	17.6%	109,420	17.7%	94,011	15.1%	110,712	17.8%
<b>Individual Market</b>	17,138	2.8%	17,718	2.9%	15,635	2.5%	10,266	1.7%	9,422	1.5%
<b>Public</b>	193,910	31.6%	193,906	31.4%	196,145	31.7%	198,914	32.0%	195,561	31.4%
Medicare	90,214	14.7%	91,170	14.8%	92,724	15.0%	94,347	15.2%	92,573	14.9%
Medicaid	103,696	16.9%	102,736	16.7%	103,421	16.7%	104,567	16.8%	102,988	16.5%
<b>Uninsured</b>	57,017	9.3%	62,892	10.2%	62,530	10.1%	64,004	10.3%	61,057	9.8%
<b>Total Population</b>	613,090	100%	616,592	100%	619,107	100%	621,394	100%	623,050	100%

Except for those dually enrolled in Medicare and Medicaid, the enrollment in private insurance has not been unduplicated.

Enrollment in military insurance is not included. In 2005, 22,102 Vermont residents reported military coverage with 9,754 of those solely reliant on military coverage.

Source: Personal correspondence with Dian Kahn, Director, Analysis & Data Management, Health Care Administration

First, employer-sponsored coverage is a better buy—not only because the employer normally pays much of the premium, but also because the employer’s contribution is not taxed as income to the employee. If employees had to purchase individual coverage on their own, not only would they be paying the full cost out of pocket, they would also be using after-tax dollars. For example, if an employer contributes \$100 toward the employee’s health insurance premium, that buys \$100 of coverage. If the employer instead gave that \$100 to the employee in higher wages, and the employee then went out to buy individual coverage, that \$100 would buy only \$65 of coverage for a person whose marginal tax rate is 35 percent. The rest would go to taxes, including federal and state income tax, Social Security tax, and Medicare tax. A person

who has to buy individual-market coverage enjoys no tax subsidy, so the after-tax cost is much higher than for the person who has employer coverage.

Second, individual coverage is generally more expensive than equivalent employer-sponsored coverage because insurer's administrative costs associated with marketing and servicing people who buy as individuals are inherently higher than for large groups or even smaller groups.<sup>3</sup> Because of diseconomies of scale, it is just more costly to market coverage and provide after-sales services to individuals on a one-on-one basis. Someone, typically an agent, has to make the sale to each individual (and be paid for doing so); each individual is separately billed; and if the person needs service, the insurer rather than the employer, has to attend to their needs.

For all of these reasons, even when the individual market performs as well as it can, it is unlikely to account for a major portion of total health coverage. For the United States as a whole, only about 5 percent of the population is covered in the individual market. Nevertheless, there are reasons to believe that the individual market in Vermont is performing poorly even in relative terms. First, as noted earlier, the number of people with individual coverage has fallen drastically. (See Figure 1.) Second, the type of coverage that is available is very limited. In essence, insurers in Vermont offer only catastrophic coverage in the individual market. The most generous policy, offered by Blue Cross and Blue Shield (as of July 2006), has a minimum per-person deductible of \$3,500 with a 20 percent copayment for services thereafter, up to a maximum out-of-pocket expense of \$6,000. The company offers policies that have per-person deductibles of up to \$10,000. Coverage offered by MPV has a 30 percent copayment provision, a per-person deductible of from \$3,500 to \$100,000, and no limit on out-of-pocket spending. Insurers report that they moved to offering exclusively this kind of catastrophic coverage because claims costs were rising so rapidly that coverage with more typical cost sharing levels was simply completely unaffordable. Even with these coverage restrictions, Blue Cross and Blue Shield reports that premiums have not covered the costs of providing coverage in the individual market in 19 of the last 21 years. The loss is about \$2 million a year. Insurers will offer what buyers will buy. If insurers do not offer coverage with lower-cost sharing, that is because it does not sell. So the third problem is that the cost of coverage is high relative to the comprehensiveness of coverage.

The sequence of events in the individual market can be summarized as follows: For reasons which are explained below, the individual market attracts a disproportionate number of high-risk people, which drives up premiums, which in turn discourages lower-risk individuals from buying coverage and causes some to leave, which further drives up premiums. Insurers try to make coverage more affordable by moving toward catastrophic coverage, where consumers pay more out-of-pocket. But this coverage is seen as inadequate by many potential customers, giving people further incentives to seek coverage elsewhere or to simply drop coverage entirely.

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<sup>3</sup> MVP, one of two significant insurers in Vermont's individual market, indicates that they believe that administrative costs in the individual market are not substantially greater than for the smaller groups, such as those with 10 or fewer enrollees, which make up a large share of the small-group market.

Because of the high costs and the limited benefit packages available, it is likely that most of the people who are left buying coverage in the individual market are those who find it impossible to get coverage elsewhere. If they had a choice, they would go to the small-group market (as a "group of one") or the association market because coverage would be cheaper. (This would not necessarily be true in states where community rating does not apply in the individual market. In that instance, a low-risk individual might find that individual coverage was less expensive than group coverage—for example, if the only group through which the person could buy coverage was a high-risk group.)

A number of people have suggested that there is another problem with the individual market: Blue Cross and Blue Shield and MVP dominate the market; no other insurer covers more than 40 lives. It appears that the other 25 or so insurers who technically still offer coverage in the state are making no effort to gain additional customers. Those who see this as a problem apparently feel that if they were more real competition, prices would be lower and a greater variety of plans would be available. However, this line of reasoning may not be sound. Even in the individual market, where administrative costs are higher, a major proportion of premium costs reflect the underlying costs of providing medical services. To the extent that insurers can affect medical costs, they would not be induced to do so just by changes in the competitive structure of the individual market alone, since the group market is a much larger share of their business. And while greater competition might cause insurers to make stronger efforts to reduce administrative costs, higher costs are inherent in the nature of the market. In short, even if there were more competitors, it is unlikely that the costs of coverage would fall by enough, if at all, to make it substantially more affordable.

Moreover because the individual market is such a small proportion of the total (in Vermont and elsewhere), it is simply not likely to attract many more insurers even if the market rules were to be made substantially more attractive to insurers. And because Vermont is a small state, the absolute size of the market will always be small. Even if the number of covered lives were to be *twice* the peak level of the past five years, it would be only about 35,000 people. And finally, the fact that the individual market has in essence become a high-risk pool deters other insurers from making a real effort to compete. Vermont's situation is far from unique, however; in most states, the number of insurers that actively participate in the individual market is small. It is thus probably not realistic to hope for any significant influx of new, aggressive insurers into the individual market under any foreseeable conditions.

## **Performance of Related Markets**

The major purpose of this paper is to try to analyze the reasons for the individual market's poor performance and to suggest ways to improve it. In addressing the problem, it is important to define what the objective is. It presumably is not really to preserve the individual market but rather to ensure that people who need coverage get it. Since people can and do move from market to market, it would be inappropriate

ate to analyze the problem of the individual market in isolation from other insurance markets. In fact, some have suggested that the solution to the problems of the individual market might be to collapse the individual and small-group markets into one. Thus it is appropriate to give some attention to the performance of the small-group and association markets as part of this analysis.

### **“Escaping” Community Rating**

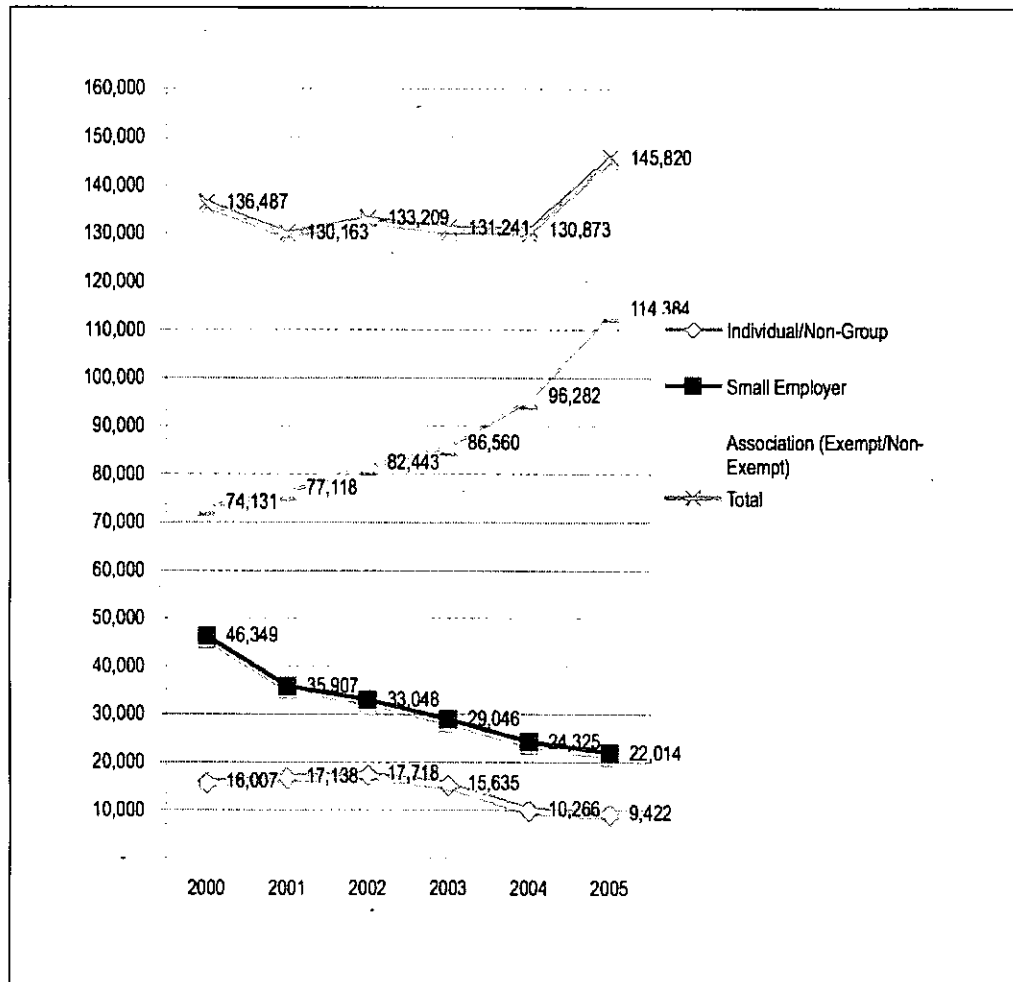
The data in Figure 4 indicate that the community-rated small-group market is also in trouble. During the five years from 2000 to 2005, the small-group market declined at an even more rapid pace than the individual market, with the number of covered lives falling by 24,245, to less than half the original level or only 22,014 lives. At the same time, the association market was growing rapidly, by 54 percent and more than 40,000 lives. In fact, the growth of the association market substantially exceeded the cumulative decline of the individual and small-group markets. This suggests, though it is not definitive proof, that people are switching from the individual and small-group markets to the association plan market. Presumably, those who switch find that the association market offers better value.

The growth of the association market compared to the individual and small-group markets suggests the difference may be due to differences in the way the premium rating rules apply in those markets:

- In the association market, insurers experience rate each association. Individual associations pay premiums that reflect the actual medical claims experience of the members, which is in turn a reflection of the combined risk of all their insured members. While community rating applies within any individual association plan, the differences in claims experience and premiums from association to association depend on the relative risk of the firms enrolled in each association.
- In the rest of the small-employer market—what we refer to as the small-group market—all insurers are required to use pure community rating, although until the mid-1990s, for-profit insurers were allowed to use age rating with a “rate band” of plus or minus 20 percent.
- In the individual market, Blue Cross and Blue Shield must use pure community rating, whereas for-profit insurers can vary rates based on age by plus or minus 20 percent; so the highest rate can be 1.5 times as high as the lowest rate ( $80/120 = 1.5$ ).

The differences in the rating rules create a structure that is bound to cause problems as long as people have the option of moving from insurer to insurer or from market to market. *The basic rule is that any time the insurance regulations allow one market segment greater latitude in varying rates than other segments, that market will grow at the expense of the markets with less flexibility to vary rates.* Eventually, the other markets will wither and perhaps fail because of adverse selection, for reasons explained below.

**Figure 4**  
**Covered Lives in the Individual, Small-Group, and Association Markets,**  
**Vermont 2000-2005**



Source: 2005 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration.

"Pure" community rating is the most restrictive form of rating regulation, and it is required of Blue Cross and Blue Shield in the individual market and of all insurers in the small-group market. The essence of community rating is that everyone in an insurer's "community" or pool pays the same premium regardless of risk. This means that individuals or groups who are temporarily or permanently at lower risk subsidize the medical costs of people who are at higher risk. Community rating can work only if all who are defined as part of the community and who decide to purchase coverage are required to stay within the community for purposes of buying insurance. If some can leave and form their own "new community," the system is headed for trouble. Under these circumstances, people who perceive themselves as being at lower risk have a strong incentive to try to form their own community so that they pay premiums that reflect their lower risk. But if the lower-risk individuals and groups are able to leave to get coverage elsewhere, the people left in the original

community will have higher average risk, and as a consequence their premiums will rise. But the rising premiums create strong incentives for those still in the community to try to escape also. The process continues in a spiral, as the adverse selection the community experiences causes everyone who has an option to try to escape to find coverage elsewhere.

Of course, the purpose of implementing community rating in Vermont in the first place was to prevent this kind of segmentation of risk. But the system as structured, which allows small employers to leave the community-rated portion of the small-employer market and escape to the experience-rated association market makes it impossible for community rating to survive. Small employers whose risk levels are better than that of the average firm left in the small-group market have strong incentives to join an association or form their own<sup>4</sup> to get a better rate. Even the higher-risk groups in the small-group market will try to leave that market and join an association if they qualify (since associations cannot deny coverage to any group that qualifies for association membership, even if they are a high-risk group.)<sup>5</sup>

This line of reasoning is completely consistent with the changes in coverage that have occurred in Vermont. As documented earlier, the community-rated small-group market has rapidly declined, while the association market has grown. The analysis is also consistent with the fact that Blue Cross and Blue Shield accounts for such a small share of the small-group market—only 486 lives out of 22,104 in 2005. Until the mid-1990s, insurers other than Blue Cross and Blue Shield were allowed to use age rating. As would be expected, Blue Cross and Blue Shield experienced adverse selection, which put them at a competitive disadvantage. The rule was changed in the mid-1990s, requiring all insurers to community rate. Why, then, now that the playing field has been leveled, is the Blue Cross and Blue Shield market share still so small? When community rating is in force, once a “community” (a risk pool) is composed of people who are older and sicker than other “communities” to which people choosing coverage can go, it is very difficult for the community with the less healthy population to recover. Because the premiums in the community reflect the higher-risk population, that community will not be attractive to lower-risk populations. If the people in the community have other options, they will leave and very few new people will enroll—a classic case of the “death spiral of adverse selection.” This appears to be what has happened to Blue Cross and Blue Shield.

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<sup>4</sup> Vermont law does not permit employers to form an association solely for the purpose of buying insurance, but it may not be difficult to attach other functions, such as publishing a newsletter to groups that have some common interest, to an organization whose main purpose is offering coverage at favorable rates.

<sup>5</sup> Insurers are likely to reinforce this natural tendency of small employers because, as a rule, insurers do not like pure community rating. If a portion of their community rated business experiences substantial losses because of high medical claims, under community rating the insurer's only alternative is to raise rates for the group as a whole. This puts them at a competitive disadvantage relative to other insurers who might not have experienced the same “bad” claims experience. Insurers prefer to be able to raise premiums for just that portion of their business that experiences a claims increase significantly greater than that of their business as a whole. Because they are not forced to raise the rates for the other parts of their business, they can remain competitive with other insurers for most of their business. So insurers have to reason to prefer to have small employers in association plans, where rates depend on the claims experience of each association, rather than in the small-group market. Thus they probably promote this business.

**Figure 5: Vermont Market Shares, Individual, Small-Group, and Association Markets, 2005**

	Covered Lives	
	Number	Percent
<b>Individual Market</b>		
Blue Cross and Blue Shield of VT	7,138	75.8%
MVP Health Insurance Co.	2,005	21.3%
All others	279	3.0%
<i>Total</i>	<i>9,422</i>	<i>100%</i>
<b>Small-Group Market</b>		
MVP Health Plan Inc.	13,685	62.2%
Vermont Health Plan	6,786	30.8%
John Alden Life Ins. Co.	804	3.7%
Blue Cross and Blue Shield of VT	486	2.2%
All others	253	1.1%
<i>Total</i>	<i>22,014</i>	<i>100%</i>
<b>Association Plans</b>		
Blue Cross and Blue Shield of VT	95,222	83.2%
Connecticut General Life Ins. Co.	12,700	11.1%
Vermont Health Plan	6,301	5.5%
All others	161	0.1%
<i>Total</i>	<i>114,384</i>	<i>100%</i>

Source: 2005 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration.

### Community Rating Problems in the Individual Market

The problems with making community rating work in the individual market are even greater than in the small-group market, and they are exacerbated by the fact that insurers are required to sell coverage on a guaranteed-issue basis—that is, to make it available to anyone at any time, regardless of the person's risk. The combination of community rating (for Blue Cross and Blue Shield) and guaranteed issue means that any individual can be assured of getting coverage at any time without incurring a financial penalty for waiting. As long as healthy people can postpone buying coverage until they anticipate needing to use expensive medical care, many will do so, and thus they are not part of the ongoing risk pool. If they then enter when they need expensive medical care, they will obviously drive up the pool's cost. The situation is analogous to being able to wait to buy fire insurance until one's house has caught on fire. (The fact that the market rules allow insurers to exclude coverage for prior conditions for a specified period of time to some extent offsets this situation, since the exclusions are a deterrent to putting off getting coverage.)

This tendency to postpone buying coverage is understandable. The financial burden of buying individual coverage is high, because there is no employer contribution and because of the high administrative cost component. People whose only option is the

individual market may have low incomes. Some may have lost a job and their coverage along with it. Others may not be able to work for one reason or another. So buying coverage on an ongoing basis may seem unaffordable—better to wait until the need seems more imminent. For young, healthy people whose risk of incurring large medical bills is low and who may have low incomes and no employer coverage, the high cost of individual coverage with its extensive cost-sharing requirements may seem a poor value.

When the lower-risk, healthy people stay out of the pool, left in the pool are a high proportion of people whose medical condition makes them feel that they must have protection of insurance, such as those with some chronic condition or those who join because they expect to incur a major medical expense in the near future. While some in the pool will be healthy and stay healthy, the average risk is likely to be high, so the average cost of coverage becomes very high. *This further discourages healthy people from buying coverage because they perceive that their relatively low risk of incurring expensive medical bills does not justify paying the high cost of coverage.* Unlike the small-group market, in the individual market, the problem may be not so much that lower-risk, healthy people escape the community rating pool—since few would be in the individual market if they had other options—but rather that they do not join in the first place.

Allowing people to buy coverage at any time without financial penalty is not only dysfunctional, it is unfair to the relatively healthy people who have not waited to buy coverage until they anticipate needing expensive services. They are paying far more than their fair share of the coverage costs, since their premiums are inflated because of the influx of people who wait to buy coverage until they know they are likely to incur significant medical costs.

The problems resulting from the fact that people can wait to buy coverage until they expect to need expensive medical care (as when planning to have a baby) is a problem in the individual market in all states except Massachusetts, which has just passed legislation that mandates that everyone acquire coverage. But the problem is worse in Vermont because of community rating and guaranteed-issue. In other states (except New York), if people wait to buy coverage until they are high risk, they will pay a premium that reflects their high risk; and if they are deemed to be especially high risk, they can be denied coverage. In Vermont, the penalty for waiting to get coverage until one is at high risk is minimal.

These policies promote behavior that is inconsistent with the basic principal of insurance, which is that people who cannot predict their individual chance of incurring a large loss join together with others in the same circumstances to spread risk, knowing that the losses for the group as a whole are relatively predictable. By incurring a small certain loss—paying the insurance premium—each person in the insurance pool protects himself or herself against the uncertainty of a large loss in the form of having to pay a large medical bill. Under these circumstances, the pool is composed of a large number of people who in any one period will incur only minor medical expenses, if any, and a few people who will incur large costs. Thus the people who are temporarily healthy subsidize those who are temporarily in need of ex-

pensive medical services. But if people can wait to enter the pool until their chances of needing expensive medical care is imminent—that is, they can predict that they will incur a large loss—the insurance principle breaks down. That is probably what is happening in the individual market in Vermont.

The expected result is what is observed in the individual market. Because of adverse selection against the market as a whole, claims costs have risen and thus so must premiums. Insurers switch to high-deductible plans. Everybody who has any alternative looks for coverage elsewhere. Enrollment falls.<sup>6</sup>

The group market is much less likely to suffer from this kind of adverse selection problem for several reasons. First, people buy coverage as a group, and when there are a significant number of people in the group, it is difficult to predict accurately when the group (that is, someone in the group) is likely to incur high medical expenses and when not. So the group cannot safely jump in and out of the market. (However, insurers report that this can be a problem for very small groups, those with perhaps one to five employees, where employers may buy coverage to protect someone with a medical problem, often the proprietor.) Although the group (that is, the employer) cannot predict when someone in the group will need coverage, employees sign up as individuals, and individual employees *can* more readily predict when they will need services. So there is danger from adverse selection from this front: only the high-risk employees might take up the employer offer. Insurers try to protect themselves from having this happen by establishing minimum participation requirements: they typically require that a minimum of 70 percent of the eligible employees sign up for coverage.

There is second important reason that explains why low-risk employees are more likely to buy employer-sponsored coverage than they would be likely to choose individual coverage if that were their only option. Employers pay a major portion of the bill. In fact, to protect themselves from having only higher-risk employees sign up, insurers typically *require* employers to pay a minimum portion of the premium, often 50 percent. They calculate that with that degree of subsidy, the coverage will be attractive to both low-risk and high-risk employees. The fact that that contribution is not counted as taxable income to the employee, as previously explained, also makes the coverage much less expensive for everybody. One other factor that discourages healthy employees from waiting to buy coverage until they think they will need it is that employers allow workers to enroll only during a limited “open enrollment period” of a month or so. For all of these reasons, group coverage is more likely to enroll people with a representative sample of risk than the individual market.

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<sup>6</sup> It is worth noting that MVP apparently is not convinced that the current rules in the individual market will necessarily cause this market to decline further. Although they have not until very recently made any attempt to market or promote their individual-market products, they have made a corporate decision to begin doing so, according to MVP officials interviewed for this report. Their decision is prompted in part, they report, by the fact that they think the individual market across the country will play a more important role as employers turn away from defined-benefit health plans to defined-contribution plans, leaving individual employees, rather than their employer, to select the insurer to cover them.

One additional feature of rating in the individual market in Vermont is worth noting, though it is perplexing. Blue Cross and Blue Shield is required to community rate in the individual market, whereas for-profit insurers can vary rates by plus or minus 20 percent based on age. Under these circumstances one would expect that younger people would abandon Blue Cross and Blue Shield for other insurers, creating a downward spiral of severe adverse selection and loss of market share. This apparently has not happened. Between 2000 and 2005, the number of people insured by Blue Cross and Blue Shield declined by 30 percent, but the market as a whole declined even more rapidly, by 41 percent. Thus, the BCBS share of covered lives in the individual market *increased* from 51.8 percent in 2002 to 75.8 percent in 2005; their revenue share also increased.

It is hard to reconcile this with the disparity in premiums among companies.<sup>7</sup> As of July 2006, the least expensive single-person BCBS policy, which had a \$10,000 deductible, cost \$255 per month (the premium does not vary by age). The carrier with the next largest market share is MVP. The *most* expensive MVP individual coverage plan costs \$254, which is the rate for a person age 64; and this is for a plan that has only a \$3,500 deductible. MVP premiums for younger people are considerably lower. The cost of an MVP plan with a \$10,000 deductible for a person age 45 was just \$139, far below the BCBS rate for their \$10,000 plan. It is true that the MVP plan has substantially greater consumer cost sharing, with a higher co-insurance rate and no upper limit to out-of-pocket expenses. This likely makes the coverage less attractive. Nevertheless, given the large rate advantage that MVP offers, it is difficult to understand how the BCBS market share has grown. The higher BCBS rates are what one would expect: because they have to community rate while other insurers do not, they would be expected to experience adverse selection. But the increase in market share seems counterintuitive under these circumstances. One explanation appears to be that MVP has made no effort to market its individual products (though it is beginning to do so now). The people enrolled are primarily those who transferred to MVP when Mutual of Omaha left the Vermont market. So people deciding to buy individual coverage may not know of the price differences. Inertia and ignorance of options may play a role. It may also be true that the few people who still decide to buy individual coverage, even though the rates are very high relatively to the scope of coverage, are those who have some ongoing condition and are unwilling to get new coverage with the uncertainties that would bring.

### **Is Community Rating Being Achieved?**

Is the state's intent to establish community rating in the individual and small-group markets being realized. Simply in terms of numbers, the answer is clearly No. The proportion of people in the community-rated portion of the market—that is, those covered by individual market coverage and small-group coverage as contrasted with

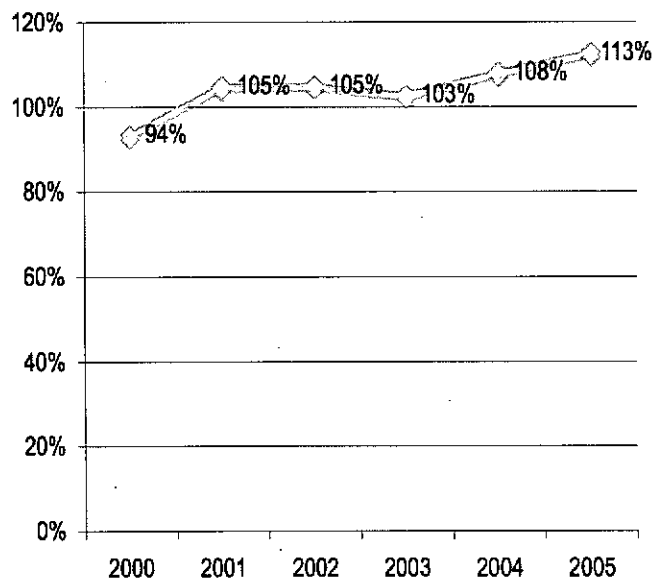
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<sup>7</sup> All premium data here and elsewhere in the paper are for July 2006 and are taken from "Consumer Tips: Shopping for Individual or Small Group Health Insurance in Vermont, July 2006, published by the Department of Banking, Insurance, Securities and Health Care Administration, Division of Health Care Administration.

association plan coverage—declined every year from 2000 to 2005, going from 46 percent to 22 percent. The objective of community rating is to spread risk equally among everyone who buys insurance: regardless of risk, everyone is to pay the same amount for comparable coverage. Clearly, that objective is not being achieved: the people insured in the association market—78 percent of people buying coverage through small employers or as individuals—are not community rated; each association is paying different rates, depending on the medical cost experience of those in the association. Moreover, the employers in association plans are no longer part of the community/pool of small-group employers. So the “community-rated” small-group market is really just a portion of the small-employer market that is *being rated separately according to that segment’s risk*, which is almost surely higher than that of all small employers as a whole. One insurer indicated that it is, in fact, seeing increasing adverse selection in this market. Another insurer representative reported that the only people left in this segment of the small-employer market are those who through either inertia or fear of change stay with the insurance they have always had, even though they could get less expensive coverage by joining an association. This is not community rating in any real sense. It is not surprising, therefore, that the average premium in the small-group market is steadily increasing relative to the average premium in the association plan market. Over the period from 2000 to 2005, the average small-group premium has risen from 94 percent of the association plan average premium to 113 percent (Figure 6). This data suggests (but does not prove, since the premium averages of the two markets are not controlled for differences in the coverage) that the cost of coverage is rising more rapidly in the small-group market than the association market—another indication that *the objective of community rating is not being realized*.

If small employers were completely free to join any association to get coverage, one would expect premium differences among associations (assuming comparable coverage) to largely disappear. If the claims experience of an association were especially favorable, so that its rates were significantly below those of other associations, one would expect an influx of employers from associations with a more risky population, since the employers could get a lower premium by making the switch. But the influx of higher-risk groups would cause rates in the association to rise. The result should be an evening out of rate differences from association to association. In fact, while there are rate variations among associations, they are not great. According to representatives of the insurance industry, rate variations among associations tend to be in the range of 30 percent to 40 percent. This suggests that there are some impediments to moving from one association to another, something to be expected given that not all employers will qualify for membership in all associations. Inertia and lack of knowledge may play a role as well, although there are anecdotal reports that association shopping has increased in recent years as the price of coverage has escalated.

**Figure 6**  
**Ratio of Small-Group Premiums to Association Plan Premiums, Vermont, 2000-2005**



Source: Calculated from 2005 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration.

### **Summary of Market Performance**

To sum up, the individual market seems to be performing badly: the number of people buying such coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing. The performance of the small-employer market is also less than ideal: the community-rated portion of the small-group market is declining very rapidly; prices in that market are rising relatively to the association plan market; and community rating is not a reality in the small-employer market as a whole. The association portion of the small-employer market has become the primary source of coverage for small employers.

### **Ways to Mitigate the Problems**

Before turning to a discussion of possible solutions, it is useful to clarify what are the objectives of reform. Presumably, the most important overall objectives are to minimize the number of people who are denied access to coverage and to increase the number of people who have health insurance. Since one of the major barriers to the purchase of coverage is the cost, ensuring that coverage is affordable for everyone, then, is a major objective.

The overall level of affordability depends primarily on the underlying costs of providing medical services. The factors that determine those costs—among them pro-

vider practice patterns, technological advance, and the overall demand for medical services—are largely beyond the influence of insurance regulation. All segments of the insurance market are suffering from cost escalation, not just the individual and small-employer markets. Curbing medical care cost escalation would certainly help to increase the number of people who buy insurance coverage, but finding ways to accomplish that difficult task is beyond the scope of this paper and largely beyond the scope of insurance reform in general.

However, insurance regulation can strongly influence the *relative* amounts that various segments of the insured population pay. Community rating is designed to make coverage more affordable for *people of above average risk*; they pay the same premium as everyone else instead of a high premium that reflects their actual risk of needing expensive medical care. While community rating is one approach to spreading risk, it is by no means the only way to make coverage more affordable for higher-risk people. We will explore several of those later.

It is important to understand, however, that any approach to making coverage more affordable—either for those who are at high risk or those who do not have the financial means to afford even average-priced care—require subsidies. Higher-risk people can be subsidized either through the insurance system, where the subsidies come from healthy people in the insurance pool, or by some more direct form of subsidy, say, a voucher or a tax credit that can be used to lower the net cost of the insurance premium for higher-risk people. For those who are unable to afford even average-priced coverage because of their low income rather than their risk, coverage cannot be made more affordable by altering the way risk is spread across the insured population. To solve that problem requires a redistribution of purchasing power from higher-income people to lower income-people, most commonly through a tax-financed subsidy mechanism, such as tax credits, vouchers, or public coverage programs.

One other objective that insurance regulation can help achieve is premium stability from year to year. Any policy that limits the extent to which insurers can base premiums on risk, including, of course, community rating, helps to produce premium stability because individuals or groups do not experience a major rate increase just because they incurred high costs in the previous rating period or added someone to the group who is older or in poor health.

In looking at the range of options for solving the problems of the individual and the small-employer markets, then, is important to keep in mind that the primary objective is to increase the number of people who have coverage, which requires making coverage more affordable for those who are uninsured or are likely to become uninsured.

### **Community Rating**

Within the overall structure of Vermont's insurance regulation, community rating is not working: it is not helping to make coverage more affordable for higher-risk people. Community rating is not working because it is not actually in force. The bulk of

the population that is potentially subject to community rating is in association plans, which are experienced rated. Allowing employers that join association plans to escape the community-rated pool thwarts the original intent of community rating, which is to have healthy populations subsidize less healthy populations.

Community rating has declined because people have been allowed to escape the community rating pool. Making the pool larger would help to solve the problem. One solution would be to require that each insurer charge the same rate for comparable coverage to all associations—community rating across all associations rather than within each individual association. No association would pay more than another for comparable coverage. Of course, the result would be reduced rates for higher-risk small employers but increased rates for lower-risk small employers. In essence, the policy would put the community-rated portion of the small group-market and the association market in a single risk pool. There would be much less incentive for low-risk employers to seek association coverage. So many of them would stay in the small-group market. Over time, the price of coverage in the community-rated small employer market would probably approximate the price within the association market. The objective of community rating would be restored. But this approach has a disadvantage: associations now have an incentive to take steps to reduce the medical costs incurred by their insured members—through health promotion and illness prevention measures, for example. One of the insurers reports that some of the associations are quite sophisticated in their approach to trying to improve health status to reduce claims costs. If community rating were to be imposed across associations, an

### **Risk Rating vs. Community Rating—Objectives and Alternatives**

In considering the alternative rating approaches—community rating vs. some form of risk rating—it is important to consider what are the objectives of each approach and what are the alternatives to achieving those objectives.

Community rating has one objective: to make coverage more affordable for higher-risk people, essentially, everyone whose risk level is above the average of those in the community (the insurance pool). Under community rating, everyone pays the average rate; so relatively to risk rating, everyone with below-average risk is a "loser," and everyone with above-average risk is a "winner." There are, of course, other ways to protect higher-risk people. At least conceptually, one alternative would be to use government tax funds to finance risk-adjusted vouchers: the subsidies would be larger for people that are at higher risk of incurring high costs. (High-risk pools are an example.) This approach spreads risk across the whole tax-paying population rather than across the insured population. Because taxes tend to be levied on the ability-to-pay principle, this might sometimes be a fairer way of spreading risk than through community rating. The subsidies implicit in community rating—from low-risk to high-risk individuals—are not based on ability to pay. In fact, younger people pay the same premium as older people, and probably on average, younger people have lower incomes than older people.

Risk-rating has two objectives: to protect insurers against adverse selection, and to make coverage more attractive to lower-risk people. There are alternatives for achieving these objectives. Risk rating provides insurers with the ability to continue to compete even if they attract a disproportionate number of higher-risk people. Because they can charge the higher-risk people more than lower-risk people, they can still compete successfully with their competitors who attract a population with a more favorable overall risk profile. An alternative way to protect insurers against adverse selection is to establish a risk-adjustment mechanism, which requires insurers with a more favorable risk selection to transfer money to insurers with a less favorable risk selection. Under a perfect system of risk adjustment, no insurer would be advantaged or disadvantaged as a result of the risk profile of their enrollees. Insurers would have equal incentives to try to attract high-risk and low-risk people.

Government-funded reinsurance is another way to protect insurers against high-risk enrollees. If the government covers a major portion of the costs of anyone who incurs high costs, the insurer's risk associated with enrolling a high-risk person is greatly reduced.

Options for making coverage more attractive to low-risk people, other than through community rating, include the two just mentioned: both risk-adjustment and reinsurance protect insurers against the costs associated with high-risk enrollees, which would lower their expected claims payout, thereby allowing them to lower their average premiums. A third option for producing increased enrollment of low-risk people is an individual mandate—requiring everyone to buy coverage. Low-risk people have no choice but to join the insurance pool.

association's incentive to reduce medical costs would be greatly reduced.

Without some such change, the community-rated small-group market will likely dwindle to almost nothing. Of course, the employers now in associations with a below-average risk profile would object to such a shift toward community rating, because they would end up paying more for coverage. One way to reduce the level of opposition would be to allow modest risk rating, perhaps based on age alone, *in all markets*—for example, to allow the plus or minus 20 percent variation in all markets. Under this rule change, lower-risk employers might find the small-group market just as attractive as the association market. But, of course, this would be to abandon pure community rating as a principle.

### **The Range of Possible Solutions for the Individual Market**

Finding solutions to the problems caused by community rating and guaranteed issue in the individual market is much more difficult. The stark truth is that as long as purchase of coverage is voluntary, the combination of community rating and guaranteed issue cannot work in the individual market because they are a recipe for severe adverse selection. About the only way to mitigate the problem in a voluntary market is to increase the financial penalties for waiting to buy coverage in order to encourage healthy people to join the insurance pool. When healthy people join, the premium prices decline, making coverage more affordable for everybody. Without moving away from community rating or guaranteed issue, getting healthy people to join early is very difficult to do. In fact, many of the options involve some modification of these two guarantees.

#### ***Longer waiting periods for pre-existing conditions***

Under present insurance rules, when someone buys coverage, an insurer does not have to immediately cover the cost of medical expenses that are related to a condition that the newly insured person had before purchasing coverage. If a person received medical advice, treatment, diagnosis, or care for an illness or condition during the six months prior to buying coverage, insurers can establish a waiting period of twelve months before they have to cover the costs of care related to that condition. The purpose of allowing these coverage exclusions is to discourage people from waiting to buy coverage until they need care. Changing the insurance rules to extend either the "look back" period for prior conditions or increasing the "look forward" period during which coverage would be excluded for prior conditions would significantly increase the risk of postponing buying coverage. For example, if insurers did not have to pay for medical services for two years that are related to a condition that the insured person had experienced any time in the last two or even three years, people who waited to buy coverage would take on a greater risk because they would have a harder time projecting their medical needs four or five years into the future. So they would be less likely to postpone buying coverage. Of course, as now, these exclusions should not apply to people who have had other forms of coverage and are switching to individual insurance without a substantial break in coverage; they have been in a insurance pool and are thus not among those who wait to get coverage un-

til they are in need of medical care. So they pose no strong threat of adverse selection.

The obvious downside of adopting this policy is that it could impose major hardships on individuals. For example, people who simply have been unable to afford coverage and then find that their economic situation improves so that coverage is affordable would face the possibility of not having coverage for conditions that require serious medical attention. Further, some people just do not have the foresight to buy coverage when they are relatively healthy.

#### ***Limiting enrollment to a short period during the year***

Another change which might help to get healthy people to buy coverage would be to limit the guaranteed-issue provision, for example, by limiting the period during which individuals could buy coverage to one month during each year or when a person's life circumstances change in ways beyond their control, as when they lose employer coverage, experience a divorce, "age out" of their parents' policy, etc. This would make waiting to buy coverage a bit more risky, since one could not simply get coverage whenever one felt it would be financially advantageous because of some impending medical need.

The disadvantage of adopting this policy is that it penalizes people who may not know the rule or who, through oversight, miss the window for enrollment. Then they might have to wait a whole year to begin coverage, which could create real hardships if they need expensive medical care.

#### ***Allowing age rating for all insurers***

Prohibiting age rating by requiring community rating raises the cost of coverage for young people, thereby discouraging them from buying coverage, which contributes to adverse selection in the individual market. Blue Cross and Blue Shield, as a not-for-profit insurer, is required to community rate. MVP, as a for-profit insurer, is allowed to vary rates based on age by plus or minus 20 percent. It is useful to see what this means in practice. MVP's monthly rates for single coverage with a \$3,500 deductible vary from \$168.68 for a 29 year old to \$253 for a 64 year old, which is exactly plus or minus 20 percent around the "community rate" of \$210.84. What this means is that if MVP were required to community rate, the 29 year old would have to pay, \$42.16 more than now, which is a 25 percent increase. That surely would discourage some 29 year olds from buying coverage.

Given the adverse selection that the individual market experiences, there is a strong case for allowing modest age rating to attract some younger people to the market—not only for for-profit insurers but for Blue Cross and Blue Shield as well. Of course, the premium increase that older people in the market would experience could create some hardship. But if the influx of younger people is sufficient, the increase might not be large. Moreover, unless something can be done to attract more younger people, the market is likely to deteriorate even further, which would be harmful to everybody in the market. While Blue Cross and Blue Shield now enjoys a larger market share than MVP, that advantage is likely to diminish over time, as Blue Cross and Blue Shield experiences adverse selection. It is worth repeating the proposition made earlier that any time one segment of the market (in this case Blue Cross and Blue

Shield) has less flexibility in varying rates based on risk, that segment will lose lower-risk participants and its long-run viability will be jeopardized. Admittedly, Blue Cross and Blue Shield does enjoy an advantage over its for-profit competitors by not being subject to the 2 percent premium tax, but that 2 percent is likely to be quickly eaten away and more by adverse selection. The only alternative then is for Blue Cross and Blue Shield to continue to lose market share or to take a bigger loss than they report now. The result would be that their other customers in one way or another subsidize the individual market, which means that they are less competitive in those markets as well.

In general, the insurance market will work much better if everyone selling in a particular market is subject to the same market rules regarding rating.<sup>8</sup> Of course, instead of allowing all insurers to age rate, an alternative would be to require all to community rate. That would produce fair competition, but it would make individual coverage even less attractive to the younger people that the market needs to attract to bring down average rates.

#### ***Lowering the price of coverage through subsidies***

The individuals who remain uninsured presumably do so because they find the price of coverage unaffordable or perceive it as being too high to make purchase a good value. The cost of individual coverage is high, especially given the high consumer cost sharing. As of July 2006, the least expensive Blue Cross and Blue Shield individual coverage plan was \$255 per month or over \$3,000 per year for one person with a \$10,000 deductible and an out-of-pocket maximum of \$7,000 thereafter. The premium for a plan with a \$3,500 deductible and a \$6,000 maximum thereafter was \$444 per month or more than \$5,300 per year. Family coverage for the same plan was almost \$2,000 per month. MVP individual coverage was less expensive, although the co-insurance rate is 30 percent rather than 20 percent, and there is no limit on the insured person's out-of-pocket payments. The coverage for a single person with a \$3,500 deductible ranged from about \$169 per month (over \$2,000 per year) for a person age at 29 to \$253 for person at age 64 (over \$3,000 per year).

Although the individual market is highly unlikely to ever account for a large share of the insured market—since people who have another option will normally find that to be a better deal—lowering the price of coverage would surely induce more people to buy coverage. The research suggests, however, that a small price reduction would not have much effect.

One way to lower the price is through providing subsidies. The most obvious way to accomplish this would be simply to offer vouchers<sup>9</sup> to people who cannot afford full-price coverage, with the subsidy being sufficient in amount to make coverage af-

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<sup>8</sup> According to officials at MVP, the company is supportive of allowing Blue Cross and Blue Shield to use age rating to the same extent as is allowed for for-profit insurers. They support "a level playing field" for all competitors, even though the present arrangement gives them a competitive advantage.

<sup>9</sup> A voucher is the equivalent to a refundable and advanceable tax credit. A refundable tax credit allows people whose tax liability is less than their credit to receive a refund equal to the difference. When a credit is advanceable, it is available as cash before taxes are due.

fordable. Tying the size of the voucher to the uninsured person's income would be necessary to ensure that coverage is affordable and would be desirable to ensure that the total cost of the subsidy program is not unnecessarily large. If the objective is to increase the number of people with insurance, these subsidies should be available to every needy person whether they buy coverage in the individual or the group market. If the objective is instead is to help just those people whose only alternative is the individual market, the subsidies could be limited to people buying in that market. However, such an approach produces what economists refer to as horizontal inequity, that is, unequal treatment of people in equal circumstances: a needy person buying individual coverage would get a subsidy while an equally needy person in the group market would not.

Subsidy policies of this sort always run into another horizontal equity conundrum: whether to provide subsidies to people who already have coverage. A low-income person who already purchases coverage is no less needy than a person at the same income level who has not. To subsidize the second and not the first is to treat people in equal circumstances unequally. But the cost of achieving horizontal equity is a much higher total cost of the subsidy program because many more people are eligible for the subsidy.

The big advantage of direct subsidy programs like vouchers is that they are very target efficient; the money goes directly to the people who are buying the coverage and is thus more likely to produce the desired effect than a more indirect approach, such as providing subsidies to employers, where some of the money is likely to go to people who would have bought coverage without a subsidy and may not be especially needy.

### **Catamount Health**

One major provision of the Catamount Health legislation that was passed in 2006 is a subsidy program for the purchase of a new kind of individual coverage. The problem is that it is available only to people who have not been insured for a one-year period or who have experienced a change in life circumstances that cause them to lose coverage. Heavily subsidized premiums will be available to people with incomes up to 300 percent of the poverty level. The coverage is decidedly more comprehensive than that available through the existing individual market: deductibles are much lower, and out-of-pocket maximums are much lower, especially for people who stay within the network. The provision that excludes people with previous insurance was presumably included to prevent people from dropping their existing coverage to get this new coverage, which is a decidedly better deal for those who qualify for subsidies. This anti-"crowd out" provision should help to keep the total cost of the subsidies down. But it does so at a severe cost in terms of producing great horizontal inequity for any people in the individual market who would otherwise be eligible for the subsidy. They pay all of the cost themselves, while others at the same income level who have not purchased coverage receive subsidies and decidedly more comprehensive coverage.

Allowing lower-income people who already have individual coverage to be eligible for Catamount Health might not be especially costly. There are now only about 9,400

covered lives in the individual market, and probably many who are enrolled would not meet the income test for eligibility for subsidized coverage in Catamount Health. However, their risk level may be higher than the people who can participate in the new program, since the assumption has been that those who have not bought coverage to this point may be lower-than-average risk individuals who either could not afford ordinary individual-market coverage or found it to be a poor value. Perhaps one way to approach the issue would be to see how many people enroll in Catamount Health as it gets underway. If there is subsidy money left over, allowing lower-income people now in the individual market to enroll in Catamount Health might be feasible. Of course, making such a change would only cause the “regular” individual market to shrink even further, but at least the hardship on people with low incomes would be reduced.

It is also worth noting that implementation of Catamount Health amounts to the creation of yet another individual market risk pool, further segmenting the individual market, which is likely to create further distortions as people seek to move from market to market to get the best value. The submarkets include the community-rated individual market (Blue Cross and Blue Shield), the age-rated individual market (the for-profit insurers), the Safety Net market, and Catamount Health.

#### **Government reinsurance**

One indirect subsidy approach is government-funded reinsurance. The approach involves having government bear costs of expenses incurred above a certain level. If the government is in effect insuring the high-cost cases, the insurers do not have to bear that cost and can lower their premiums in direct proportion to the part of the cost borne by the reinsurance. To give a real-world example of the potential effects of reinsurance, consider the individual market coverage that MVP offers. As of July 2006, a 45 year old person buying an MVP individual plan with a \$5,000 deductible, pays about \$175 per month, whereas the same person buying a plan with a \$100,000 deductible would pay \$15 a month. The difference between the \$175 and \$15 per month is equal to the extra cost that MVP incurs for offering the more comprehensive coverage. If the government “reinsured”—that is paid—for all medical claims between \$5,001 and \$100,000, MVP’s charge for the \$5,000 deductible policy would need to be only \$15 instead of \$175. (This example is not meant to suggest that a good threshold level for reinsurance to take effect should be nearly as low as \$5,000.)

In this example of MVP coverage, the insured person would still be liable for 30 percent of expenses over \$100,000. For the very few people who incur really catastrophic medical bills, this is not very good protection. It is probably better policy, in terms of providing financial protection for insured people, to have the government absorb a major portion, for example, 70 percent or 80 percent, of *all* costs over a certain amount with no upper limit, with the insurer rather than the insured person picking up the rest. It is important that the insurer continue to bear a significant portion of the high-cost cases so that there is still an incentive to keep those costs as low as possible by properly managing the care.

The cost of such a reinsurance subsidy obviously depends on the point where the government reinsurance takes over and the proportion of the cost above that level

that is borne by the reinsurance rather than the primary insurer. There is a trade-off, of course: the more of the cost borne by the reinsurance, the lower the premium and the more affordable the coverage to the person buying insurance, but the higher the government's cost. Actuaries and/or economists can estimate what the trade off is. If a budget limit is in place, one appropriate policy would be to start with the rule that the reinsurance will absorb perhaps 70 percent or 80 percent of all costs over the threshold amount, with the primary insurers absorbing the rest. Given the budget limit, the models can estimate what threshold level could be financed within the budget, what premium reduction this would produce, and how many new people would take up insurance under these circumstances.

It is important to recognize that a small reinsurance subsidy is not likely to be very effective in lowering rates and making coverage more attractive to lower-risk people. The rough rule of thumb is that in any population for a given period, approximately 10 percent of the insured people accounts for about 70 percent of the costs. A reinsurance mechanism that covers only 5 percent of the costs—as is contemplated as the beginning level of subsidy in Catamount Health—is not going to cover very many high-cost cases. Very little of insurers' risk is passed on to the reinsurance, and so premium reductions will also be very slight, presumably only about 5 percent.

One potential disadvantage of reinsurance is that it requires using government funds to subsidize some people who are relatively affluent, already voluntarily buying coverage, and paying all the costs themselves. A reinsurance program of this sort lowers the price for *everybody* in the affected market, not just those who would otherwise not buy coverage or those who already buy coverage and are needy. This raises the government cost and is not particularly target efficient. But if most of the people currently in the individual market are people who are having a hard time affording coverage, the inefficiency may not be a severe problem.

In effect, what government-funded reinsurance does is to create a "social insurance" mechanism (somewhat like Medicare) for catastrophic medical costs: it uses government funds to buy catastrophic coverage, leaving insurers to provide coverage below the catastrophic level. Since the funds to finance such social insurance programs normally come from broad-based taxes, this is probably an equitable way to spread the risk across the whole population. It is important to recognize that a reinsurance mechanism that is modestly funded and confined to the individual market will not have a major impact on reducing the number of uninsured people.

#### ***Establishing a high-risk pool***

Some states have established a separate insurance mechanism or risk pool for very high-risk people. This is typically done for those people who have been denied individual-market coverage because insurers determine that their risk is too high. These people are then separately rated, and government subsidizes the premium price to make it more affordable. In many states, the high-risk pools have not been very effective because they are underfunded: they either have had to close off the pool to new entrants, or the subsidies have not been sufficient to make coverage affordable for all who need access to this form of coverage.

In Vermont, unlike most states, no one can be denied individual coverage, so there is no need for a risk pool for such people. Partly because of the community rating and the guaranteed-issue requirements, the individual market appears to have become a de facto high-risk pool. It probably would not make sense to divide out a portion of those in this market segment and separately subsidize them. Instead, a more defensible approach would be the voucher kind of approach previously discussed, which would directly provide money to needy people to make coverage affordable.

### ***Combining the individual and small-group markets***

Some people have suggested that it would be worth considering the merits of combining the individual and small-group markets. Each insurer would have to create a single risk pool composed of all the individuals and all the small employers they enroll and then presumably establish a single community rate based on the experience of that pool. That policy would eliminate the advantage enjoyed by the for-profit individual insurers relative to Blue Cross and Blue Shield that accrues from the ability to vary rates based on age. That would probably be a desirable result. But it would almost surely create other problems. (The alternative would be to allow age rating in the combined market.)

As explained in detail earlier, individual-market coverage is especially costly for two reasons. First, it is inherently more expensive to market to and service individuals than groups because of the diseconomies of scale. Second, when there is no mandate to acquire coverage, individuals tend to buy coverage when they know they are going to need it and not buy coverage when they think they will not incur high medical expenses. For both reasons, individual coverage is substantially more expensive than group coverage, especially large-group coverage. Merging the two markets does not change either of these conditions: it will still be more expensive to serve individuals, and healthy people will still postpone buying coverage. Thus in the short run, the only way a merger of the individual and small-group markets could help the individual market would be by hurting the small-group market. This is simply a mathematical truism. A merger could cause individual-market premiums to fall only if the enrollees in the small-group market are absorbing some of the costs formerly borne by those enrolled in the individual market—that is, paying higher premiums. Such a cross subsidization of one market by another may be justified as a way of spreading costs, but only if it does not produce bad overall consequences. Since the small-group market is already in trouble—and almost certainly because of the cost of coverage—it does not seem like good or effective policy to take steps that exacerbate the cost problem for that market. If costs were much lower in the small-group market than in the individual market, or if there were vastly more people enrolled in the small-group market than the individual market, then merging the two would probably not have much effect on the small-group market premiums. But neither of those conditions holds in Vermont. Even in the long run, a merger could not be very beneficial unless those two conditions exist. If they did, a merger might cause individual premiums to fall by enough to attract more lower-risk people into the market, which would have a favorable effect on premiums in the merged market.

The groups currently in the small-group market appear to be at somewhat higher risk than those in association plans. Since they already pay a higher price, it seems counterproductive to force them to subsidize the high-risk people in the individual market. While the temporary result might be a reduction in individual-market rates, the likely result would be a further deterioration of the small-group market, with the likely result of ever-rising premiums and declining enrollment. Forcing small groups to subsidize individuals is probably not good policy and is likely to cause fewer small groups to buy coverage. Under current conditions, neither market is likely to benefit from a merger.

A merger of the individual and small-employer markets would probably be a more feasible policy if everyone were required by law to purchase insurance—which is discussed below. (Massachusetts recently passed legislation requiring everyone to acquire coverage and at the same time merged the individual and small-group markets.)

#### ***Combining the "Safety Net" with the individual market***

In 1992, when the state made major reforms in its insurance laws for the small-group and individual markets, a number of insurers serving these markets left the state. Blue Cross and Blue Shield was required to make coverage available to the people who had been insured by the firms that withdrew. The new insurance was to be "substantially similar" with respect to coverage and price. The law also limited rate increases for this population to no more than 15 percent per year. This provision was seen as necessary because the people in this program were thought to be a lower-risk population than the rest of the population insured by Blue Cross and Blue Shield, and had they simply been community rated with that population, they would likely have been subject to major premium increases. This "Safety Net" program continues to this day.

Blue Cross and Blue Shield reports that the 3,000 to 3,500 people in this program, even after 15 years, are not paying sufficiently high premiums to cover the cost of insuring them. It is understandable why the legislature originally in 1992 wanted to protect this group against precipitous rate increases, but it is not clear that continuing to subsidize their rates is good policy. Anytime one group pays less than the costs they incur, some other group the insurer covers has to pay more than their costs. If Blue Cross and Blue Shield is generating the money to cover Safety Net losses by increasing premiums in the individual market, this may be one reason for the poor performance of the individual market. Moreover, if this is the case, it is an instance of significant horizontal equity: people in the individual market are paying substantially more than people who are otherwise in equal circumstances in the Safety Net Market. A Blue Cross and Blue Shield study conducted by Milliman in 2005 estimated that combining the individual and Safety Net rating pools into one pool would cause a 30 percent reduction in individual market rates and a 38 percent increase in Safety Net premiums. If this estimate is accurate, the merger would likely make the individual market more attractive to younger, healthier populations, although some of the Safety Net people would probably drop coverage or get coverage from other sources. The conceptual case for combining the markets is strong. To

prevent a huge one-year jump in Safety Net premiums, it might be wise to require that the equalization of premiums be achieved over a three- to five-year period.

***Altering treatment of "groups of one"***

In many states, self-employed individuals do not have the option of buying group coverage, but in Vermont these "groups of one" legally qualify for small-group or association plan coverage. Although they have the option of choosing individual coverage, probably very few do, because coverage as a small employer will almost always be less expensive, since the individual market is composed of people of higher risk and administrative costs are higher. The question is, then, whether it is good policy to permit groups of one to buy small-employer coverage or whether their only option should be the individual market.

The answer depends on the average risk profile of groups of one compared to the risk profiles of the individual market and the portion of the small-group market that is composed of firms with two to fifty employees. Insurers generally report that, when making decisions about buying coverage, groups of one behave similarly to people buying individual coverage: they are likely to postpone buying coverage when they are healthy and to enter the market when they expect to need expensive medical care. Some individuals apparently even form business primarily to qualify for less expensive coverage. In other words, groups of one are disproportionately higher risk and thus more expensive to insure than groups of two to fifty. Blue Cross and Blue Shield reports, however, that for their business, the risk profile of the groups of one falls somewhere between that of the individual market and the rest of the small-group market. If that is true generally in Vermont, redefining the small-group market to exclude groups of one, thus leaving these individuals with the individual market as their only option for coverage, would cause rates to fall slightly in the small-group market and perhaps in the individual market as well. The beneficial effect in the individual market would depend on how many of these people, all of whom would face higher premiums, would continue to buy coverage rather than simply go without insurance entirely. If, on the other hand, the risk profile of groups of one is essentially the same as the individual market, forcing groups of one into that market would have no beneficial effect on that market, though it might lower premiums slightly in the small-group market.

***Requiring everyone to buy coverage***

Because people in the individual market (in Vermont and other states as well) often wait to buy coverage until they expect to incur high medical bills, the individual market is composed of a disproportionate number of higher-risk people, so that risk is not spread broadly, and premium costs are high. One very effective way to eliminate this adverse selection problem is to require everyone to have coverage, as Massachusetts has very recently done. If everyone, including people whose only choice is the individual market, had to buy coverage (or face some significant penalty), young healthy people would not stay out of the risk pool, premiums would decline

substantially,<sup>10</sup> and community rating would work well. Rates would probably still be somewhat higher in the individual market because of the higher administrative costs, but the risk pool should be similar to that of the market as a whole. A merger of the individual market and small-employer market—essentially, applying community rating to a pool composed of both markets—could work under these circumstances. Small employers would still be subsidizing the higher administrative costs of the individual market, but they would not be subsidizing a higher-risk population. If the new combined market were served by an insurance exchange—a “Connector” in the Massachusetts law—that helped to facilitate the sale of all coverage and enrollment through a single entity, some administrative savings might be realized.

With a mandate of this sort—reflecting the philosophical position that everyone should bear responsibility for protecting themselves and their family—community rating would work well across the entire market. Some insurers might still experience some adverse selection because of insured people’s preferences or an insurer’s past history that leaves them with an older, sicker population. So it might be desirable to establish a risk-adjustment mechanism so that insurers that end up with a disproportionate share of lower-risk enrollees would compensate those with disproportionate share of higher-risk enrollees. With such a policy in place, insurers would have little incentive to avoid higher-risk enrollees and favor lower-risk enrollees.

The major advantage of a mandate is that it goes a long way to ensuring that everybody has coverage. Only the people who fail to heed the mandate and then have to pay the penalty are left uninsured. Presumably, over time, the number in this category would be small if the penalty is sufficiently severe.

There are two principal disadvantages to an individual mandate. The first is that it involves a degree of compulsion that some people find objectionable and unwarranted. It requires people to buy coverage they may not want. The second is that it is impractical unless it is accompanied by policies to subsidize the cost of coverage for those for whom it would otherwise be unaffordable. It would be unjust and ineffective to require people to buy coverage if they cannot afford it. But to provide subsidies large enough to make coverage affordable for everyone would be expensive, a significant new cost for state government.

Without a mandate requiring people to acquire coverage, it is hard to make the individual market perform well. But the political and economic barriers that would need to be overcome to implement a mandate are far from trivial. One way to move partially in this direction would be to start by requiring higher-income people who can afford coverage but remain uninsured to pay into a system to subsidize the uninsured. In Vermont in 2005, about 6,700 individuals whose income fell between 300 percent and 399 percent of the federal poverty level (\$60,000 to \$80,000 for a family of four in 2006) were uninsured. Another 6,800 whose income was at least 400 per-

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<sup>10</sup> A 2005 study commissioned by Blue Cross and Blue Shield of Vermont, done by Milliman, estimated that rate reductions would be somewhere within the range of 12 percent to 26 percent.

cent of the poverty level (above \$80,000 per year for a family of four in 2006) were uninsured. Together, the uninsured at these two income levels accounted for 22 percent of Vermont's 60,000 uninsured in 2005.<sup>11</sup>

If the state decided to ask uninsured higher-income people (however defined) to help fund coverage for the uninsured, the penalty for remaining uninsured could be relatively modest, enough to encourage enrollment but not as much as people would have to pay to buy coverage. If they decide to buy coverage rather than pay the penalty, that is a desirable result. If they decide to pay the penalty, that would produce some money to help subsidize uncompensated care and coverage for low-income and higher-risk people.

#### ***A universal coverage system that guarantees coverage to all***

For the sake of completeness, it is important to note that a universal coverage system that automatically gives everyone the right to coverage could, if constructed properly, solve all the risk segmentation and rate variation problems. The most obvious example is a so-called "single payer" system, in which everyone is covered by a single government program. In this instance, there is one risk pool that contains everyone. There would be no individual, small-group, association, or large-group markets. Risks are shared as broadly as possible, through the tax system that finances the program. The same result can be achieved, however, by many other universal coverage mechanisms that automatically cover all citizens. For example, a state could construct a system that would guarantee coverage for everyone but would allow citizens to choose from a number of insurers. The system could be funded by a combination of general fund revenues, employer payroll taxes, and income-based individual premiums. Insurers would community rate everyone, and a risk adjustment mechanism would ensure that insurers that attract high-risk enrollees would not be competitively disadvantaged.

The obvious advantage of these universal coverage approaches is that they ensure coverage for everyone. The disadvantages are significant. Most would require a major restructuring of the insurance/financing system, which would create major winners and losers. And they would be costly—not so much in terms of total health spending, which would probably not increase greatly, given the small proportion of uninsured people in the state—but in terms of government's budget, because government would have to fund much of the increased cost through some form of assessments on employers and/or households.

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## **Summary**

The problems of the individual market in Vermont are severe, and the only solutions that seem to offer substantial promise of resurrecting the market are either politically

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<sup>11</sup> Brian Robertson et al., Vermont Division of Health Care Administration, 2005 *Vermont Household Health Insurance Survey: Final Report*, Tables 21 and 22.

or budgetarily costly. In short, there are no easy answers—no small, incremental policy changes that will solve the problems once and for all. A major purpose of this paper has been to provide an objective analysis of the causes of the problems and to lay out the advantages and disadvantages of various approaches to address them. The analysis certainly suggests that some options are more likely to be effective than others. But ultimately state policymakers have to make the difficult decisions about what approaches are likely to be both practical and effective, given the constraints of the current political and economic environment.

Problems with the individual market are not unique to Vermont. Probably few states can claim that the individual market works really well. Because people tend to come into the market when they need coverage, creating adverse selection, most states have allowed risk rating and even denial of coverage to high-risk individuals, as a way of drawing in lower-risk people. But that creates serious access problems for higher-risk people. Vermont has tried to address the access problem for high-risk people by requiring community rating and guaranteed issue, but the result has been severe adverse selection.

If the state were willing to provide one or another kind of substantial subsidy—whether vouchers to individual higher-risk people or a well-funded reinsurance program—the individual market could be made to work better. But these approaches require a significant budgetary commitment.

Passing legislation to require everyone to acquire coverage would go a long way toward ameliorating the problem, especially if community rating were extended over all of the small-group and individual markets. But imposing an individual mandate may be a political challenge, and it is feasible and fair only if the state is willing to guarantee that coverage will be affordable.

A universal coverage plan that makes all residents automatically eligible for coverage in a single statewide pool or a series of pools with transfers from one pool to another to adjust for differences in the pools' risk profiles would also solve the problem. But both the political cost and budgetary cost would be substantial.

In any case, the state probably needs to decide whether it is committed to community rating or not. If it is, the community rating pool should be made larger, to include at least all of the small-employer market and, if there were to be an individual mandate in force, probably the individual market as well. Further segmentation of the market is not the answer. If not, the state should probably allow all insurers participating in the small-group and individual markets to age rate to the same degree. Asking some insurers and some markets to be subject to community rating while others are allowed to risk rate is an invitation to risk segmentation, wide premium differences, market dysfunction, and ultimately market failure.